Missouri Women's Health:

Setting a New Direction

Women's Health Strategic Framework

Office on Women's Health

Missouri Department of Health and Senior Services

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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

Why Focus on Women's Health?

There are many reasons for focusing on women's health, as separate and distinct from men's. Consider these stories.

Alma, a 40-year-old woman, complains to her physician over a period of several days about fatigue, sore shoulders, and acid indigestion. He tells her to get more rest, a massage, and to take over-the-counter antacid tablets. Alma collapses at work one day and is taken to the emergency room, where it is found she has had a heart attack.

Betty, a young woman with three children receives a note from her children's school telling her that the school nurse has weighed and measured the children and found that all three are obese. She is shocked and upset and has no idea how to respond to the school's directive that she make sure her children lose weight.

Carina, a 55-year-old woman, is helping to raise her two young grandchildren while her daughter, their mother, is in the armed forces, serving overseas. She also is caring for her 60-year-old husband who has severe diabetes, heart disease, and many related problems. Carina's parents are in their late 70's with several chronic diseases between them, so she is their main source of support, transportation to health care visits, and shopping, cooking, and housecleaning. Carina is beginning to find herself short of breath and fatigued, and wonders if she should see her physician. But she cannot imagine where she would find the time to do so.

Dolores, is 15 years old, pregnant as a result of being raped by her 34-year-old boyfriend, estranged from her family, and living alone in abandoned buildings in a large urban area. She goes to the hospital in labor, delivers a six-pound baby boy, then, with no health insurance, is released from the hospital the same day. The cab ride back to the area she had been living in costs her $8 of her last $10. The next day, hungry and not sure what to do about her baby's crying, Dolores leaves the baby and walks to a nearby liquor store (the only store within several blocks) in hopes of finding some food. When she begins to hemorrhage and collapses in the store, she is taken back to the hospital, but her baby is forgotten in the confusion. By the time Dolores is able to tell hospital personnel about her baby, someone in the area has heard the baby crying, has called the police, Children's Protective Services has become involved, and her baby is put in foster care.

Susanna, a young woman who dropped out of high school to get married and have her first baby now finds herself divorced and solely responsible for supporting her four children. With no high school diploma and no job skills, Susanna has been able to find only minimum-wage work (cleaning motel rooms), and she cannot both shelter and feed herself and her children on her full-time earnings. Susanna and her children now are being evicted from the apartment they have lived in since before the husband and father left.

Ruth, an eighty-year-old woman, is living fairly comfortably on her own, in the home she lived in with her husband until he died six years earlier. It is an older home, in need of repair, but she is making do, until the day she trips on a loose stair tread, falls, and breaks her hip. Following surgery, Ruth has no one to care for her as she recuperates at home, so she is placed in a nursing home, where she rapidly becomes disoriented and stops eating. Ruth's hip does not heal well, and she becomes bed-ridden and despondent.

There are many such stories. They are stories of women's lives, and they are answers to the question, "Why focus specifically on women's health?" Women have life issues different from men's, as well as specific gender roles. A woman's ability to become pregnant and bear children has profound implications for every aspect of her life. Even though the situation is slowly changing, most research about diseases and disorders is done on men, and the findings applied to women, to their detriment. As more research is focused on sex-based differences in health, the findings clearly are indicating that sex matters, that women and men respond very differently to diseases, to interventions, and to medications.

Moreover, women are the major health decision makers for their families—from the groceries they buy and the food they prepare, to setting up regular preventive health care visits for their children and husbands, to encouraging their families to be physically active and not allowing tobacco use, and on and on. Further, evidence is emerging that the healthier women are before they conceive, the healthier the pregnancy and birth outcomes. One model employing this evidence is the Perinatal Periods of Risk approach which suggests that maternal health, maternal care, newborn care, and infant health care are the major determinants of fetal and infant mortality.[1]

This Strategic Framework for Women's Health has been developed in response to the issues illustrated by these and other such stories, to set a direction for better health for all women in Missouri. The Framework summarizes the main issues affecting the health and well being of Missouri's girls and women, and suggests strategies for addressing those issues. The Framework is intended for use by advocates, planners, and policy makers in the Missouri General Assembly, state and local government agencies, academic settings, and community organizations. Between July 2003 and February 2004, the Office on Women's Health in the Department of Health and Senior Services (DHSS) provided leadership and staff support to the planning committee, composed of members of the Women's Health Council (advisory to the Office) and numerous stakeholders, as they developed the Framework. (See Appendix A for a list of planning committee members.)

Most Prevalent Women's Health Issues in Missouri

In 2002, the Missouri population was estimated by the Missouri Census Data Center to be 5,672,579, with girls and women representing 51.3 percent of the total population. Girls and women under age 45 accounted for 61 percent of the female population; those aged 45-64 represented 24 percent; and those aged 65 and older accounted for 15 percent. The population of

women and men was very similar for all age groups, with the exception of a significantly larger number of women in the older age group. Of Missourians aged 65 and older, 59 percent were women. These statistics closely mirror those of the nation as a whole.

In 2002, 85 percent of the female population was white, 11.9 percent African-American and black, 1.3 percent Asian, and less than one percent (0.4%) Native American and Alaskan Native. Two percent of the female population reported Latino or Hispanic ethnicity. These racial and ethnic estimates are quite similar to population rates reported in 2000.[2] While there was no significant change in the estimates from 2000 to 2002, it is important to note that the Hispanic population in Missouri increased by 92 percent from 1990-2000, and for those ten years, 18 Missouri counties reported a 200 percent or greater growth in their Hispanic population.[3]

The major health issues for girls and women in Missouri identified by the planning committee are listed below:

1. Heart disease and stroke
2. Cancers of the lung, breast, and cervix
3. Other chronic diseases and conditions (diabetes, osteoporosis, arthritis)
4. Reproductive health concerns (sexually transmitted diseases, teen pregnancy, unintended pregnancy, infertility, lack of optimal birth spacing, lack of preparation for pregnancy)
5. Violence and injuries
6. Exposure to/use of harmful substances, especially tobacco.
7. Access to comprehensive and coordinated health care, including oral health, mental health, and reproductive health care, as well as care for persons with HIV/AIDS

This list of issues is the result of a multi-step process that began with identification of pertinent national and Missouri women's health status indicators. In the next steps, the Office on Women's Health staff and DHSS epidemiologists identified the following16 issues, a mix of risk and protective factors and diseases and conditions, that are important to women's health nationally and in Missouri: (1) physical activity; (2) overweight and obesity; (3) tobacco use; (4) substance abuse; (5) responsible reproductive behavior; (6) eating five fruits and vegetables a day; (7) mental health; (8) injury and violence; (9) immunizations; (10) access to health care; (11) autoimmune system problems such as arthritis; chronic diseases such as (12) heart disease (13) cancer; (14) stroke; (15) chronic obstructive pulmonary disease, or COPD; and (16) diabetes.

Finally, the planning committee reviewed that list of issues and supporting data and employed a prioritization process loosely adapted from the needs identification and ranking process used for developing the DHSS Maternal and Child Health Block Grant Application for fiscal year 2000. The six criteria used for prioritizing were: (1) effective interventions exist for addressing this issue; (2) not addressing this issue will result in serious health-related consequences; (3) partners exist to help with this issue, and they identify it as a priority; (4) there is positive movement on this issue already; (5) addressing this issue is politically feasible; (6) there are resources available for addressing this issue.

Planning Assumptions

The planning group that produced the Women's Health Strategic Framework worked from the following assumptions.

1. Health comprises five interrelated dimensions — physical, emotional, social, spiritual, and intellectual. All dimensions must be considered in developing approaches to promoting good health.

2. Individual behavior change is not enough to produce good health. What is needed for optimal health is a "health promoting environment" in which it is easy for individuals to make healthy choices.

3. There are five levels of influence, or levels at which change can occur: (1) individual; (2) interpersonal; (3) organizational; (4) community; and (5) policy. In planning to improve the health of girls and women, strategies must be aimed at one or more of these levels.

4. Access to care is the single, overarching issue in women's health.

5. In order to provide maximum flexibility, the Framework must stop short of being a strategic plan. Therefore, the Framework identifies only goals and strategies. Identification of action steps and timelines, outcome measures and resources will be the responsibility of policy makers and planners who adopt this Framework in whole or in part.

Protective Factors and Determinants of Health

The Framework is organized according to factors that protect girls and women from disease, disability, and premature death, rather than according to the selected diseases and conditions themselves. In the pages that follow, there are goals and strategies for each of the following six protective factors: access to comprehensive care, including access to targeted services for high risk populations and access to reproductive health care; physical activity and healthy nutrition; freedom from environmental health hazards; avoiding tobacco and other harmful substances; healthy relationships, and safety.

In addition, there are issues that are not always recognized as related to health but that can have a significant impact on health. For example, socio-economic status (income and education), race/ethnicity/culture, and existence of social support networks are three very important determinants of health. In fact, Healthy People 2010 states that while just over two-thirds of premature deaths in the US are the result of behavioral and environmental factors, almost one-third are tied to factors such as access to quality care, social environments, and policies and interventions.[4] The first three goals in this Framework address three important determinants of health: education, income/economic security, and access to quality care.

Education and Economic Security

Goal: Missouri women will enjoy enhanced economic security.

Goal: Missouri women will be better able to make decisions that will promote good health for themselves and their families.

In general, income levels parallel educational attainment, and the link between income and health status is well established. High school graduation is an important determinant of social and economic status as well as a predictor of some of the risky behaviors that lead to negative health outcomes. In 2000, 18.8 percent of Missouri women aged 25 years and older reported that they did not graduate from high school.[5]

In 2002, the Institute for Women's Policy Research issued a report, "The Status of Women in Missouri."[6] The report compares Missouri and neighboring states (Iowa, Kansas, Minnesota, Nebraska, North Dakota, and South Dakota) on a number of indicators of well-being, including education and economic security. This report states that women's economic well-being has been compromised in the past few years because of the policy and program changes made in response to the state's fiscal woes and budget reductions. Missouri women rank very high, compared with other states in the region, on women's median annual earnings and women's participation in the labor force. Interestingly, nearly 75 percent of those in the labor force are mothers of children under age 18, a much higher percentage than nationally. Missouri women rank lower on the ratio of women's earnings to men's, and Missouri receives the lowest possible ranking in the area for the number of women in managerial and professional occupations. These data support the need for improved education and economic well being for women in Missouri.

Missouri is one of a handful of states that allow women receiving Temporary Assistance for Needy Families (TANF) to be enrolled in post-secondary education as a work activity. Since higher education degrees generally translate into better-paying jobs, this can be an important route out of poverty for women. However, a recent evaluation of TANF participants reports that most former TANF recipients remain poor.[7]

Examples of the current economy's negative impact on Missouri women include the following[8]

- √ Changes in Medicaid have reduced numbers of persons eligible. As more women than men rely on Medicaid, these changes make it more difficult for women to obtain economic stability for themselves and their families.
- √ Reductions in state subsidies for child care and in state support for the Grandparents as Foster Parents grant have created hardships for low-income women trying to go to work and for families, especially older women, who are attempting to raise their grandchildren.
- √ Lack of consistent payment of child support by non-custodial parents leaves many women and children without enough money to live on. Even though many of the non-custodial parents are them-

selves in dire financial straits, non-receipt of this important support leaves women-headed families at an economic disadvantage. It is estimated that in Missouri, only 25 percent of families who are owed child support actually receive the full amount, and most of these families are headed by women.

strategies for education and improved economic security

1. Adopt educational policies that support development of analytical and decision-making skills for girls and women at all levels of schooling.
2. Adopt educational policies that promote women's health literacy at all levels of schooling.
3. Adopt policies that promote high school graduation or attainment of the General Equivalency Degree (GED) for girls and women.
4. Enhance existing career development programs and develop new ones for high school and post-high school age young women, including a focus on careers considered non-traditional for women.
5. Provide economic support for women of all ages seeking post-high school education and training.
6. Develop mentoring programs and technical assistance and support for women returning for further education in their middle or later years, especially those women whose earlier schooling may not have equipped them to use computers and other information/communication technology.
7. Develop or expand re-entry programs that provide assistance to women who have stepped out of the work force and who may need to re-validate licenses or upgrade skills to re-enter the work force and be competitive.
8. Develop employment policies that encourage and support under-employed women to complete their educations and/or engage in further or additional training so they can move up through career ladders and lattices.
9. Develop consumer education programs and materials that support women in developing effective communication for use with health care providers and business and trades people and in transactions with banks, mortgage and credit companies, and automobile sales and repair establishments.
10. Adopt and enforce strong policies regarding child support payment and collection, and educate women about their rights to this support.
11. Adopt wage levels that promote economic self-sufficiency for both men and women.
12. Encourage policies that promote wage equity between men and women.

Access to Comprehensive Care

Goal: All Missouri girls and women will have access to comprehensive, culturally sensitive primary care and oral health and mental health care.

Access is a complex issue, influenced by many factors, including the availability of health care providers. Some providers, such as those of oral and mental health care and substance abuse treatment, are in significantly short supply in Missouri, especially in rural areas. As of January 2004, all but four counties in Missouri were designated as either geographic or low income primary care health professional shortage areas (HPSA).[9] Geographic HPSAs are designated by a ratio of primary care physicians to the entire population, while low income HPSAs are designated by the proportion of care provided to Medicaid and uninsured patients. Interestingly, while the number of geographic HPSAs has decreased by 25 percent over the past five years, low income HPSAs have increased by more than 1,000 percent.[10]

Widely differing reimbursement rates for different types of health care services and providers is another factor influencing access to care, leading to providers' unwillingness to accept certain payer sources or to offer certain kinds of services. As well, a coordinated system is needed for reimbursing uncompensated/charitable medical care.

Transportation is a significant issue in areas of this very rural state that have no or inadequate public transportation: it can be difficult or impossible for women living in rural areas to get to health clinics, hospitals, and other facilities. Lack of insurance and underinsurance are other reasons women do not get health care. Even if women have insurance and are able to see health care providers for diagnosis of health problems, if their health insurance has high deductibles and co-pays and/or restrictions on benefits, they may not be able to get follow-up diagnosis and or treatment. In 2003, 11.5 percent of women in Missouri reported having no health coverage (10.8 percent of white women and 17.8 percent of African American and black women). These rates are well above the Healthy People 2010 target of no more than four percent of the population being without health coverage.[11]

The way that health care services are organized and delivered can present barriers to care. Too often, women must receive separate authorization and make separate appointments for separate procedures and must travel from one location to another for laboratory tests or clinical preventive services (such as mammograms). If comprehensive care for women existed, as the goal below calls for, all needed services for the whole woman, including clinical preventive services and follow-up diagnosis and treatment, primary care, acute care, and rehabilitative services would be provided seamlessly for girls and women across the life span.

Finally, as immigration changes the demographic face of Missouri, cultural and linguistic barriers to care will demand more attention and action. In many localities throughout this state, community health centers and county health departments are responding creatively to meet the health care needs of immigrants. Measures such as hiring clinic staff who look like, share the cultures of, and speak the languages of the growing immigrant populations are vitally

important, but payment for services remains a major problem. Most immigrants face eligibility restrictions for publicly funded services such as Medicaid and other, supportive human services. For a variety of reasons, including lack of legal status and fear of deportation, as well as lack of knowledge of how the health care system in this country works, immigrants can be a difficult population to reach with health education. Many receive what little care they get in hospital emergency rooms, leaving hospitals with a growing uncompensated care burden. Lack of access to care is more often than not the rule for immigrants.

strategies for access to comprehensive care

1. Increase the numbers of health care providers available in all parts of the state.
   - Address the rising malpractice/liability insurance costs of health care providers and transportation providers.
   - Provide more and larger scholarships to encourage training of additional providers to serve the underserved.
   - Promote and support training, placement of, and supervision and consultation for advanced practice nurses, physicians' assistants, and other non-physician care providers within their scope of practice.
   - Enhance the program of recruiting, educating, training, and retaining dentists and oral health ancillary providers.
   - Support efforts to create a reasonable and stable source of funding for telemedicine.
   - Provide better education locally about availability of and ways to access health care providers, using such venues as pharmacies, libraries, public health agencies, churches, and senior centers.
2. Make changes in policies governing health care coverage.
   - Work with state government executive departments to enhance their efforts to develop integrated / collaborative service systems that have common enrollment and eligibility criteria.
   - Enact Medicaid protections such as increasing reimbursements, especially for oral and mental health and substance abuse providers, and expanding eligibility.
   - Require private insurers to cover mental health disorders and substance abuse on the same basis as physical disorders, without decreasing the coverage for physical disorders.
   - Improve coordination of care among primary care providers, mental health providers, and substance abuse treatment providers.
   - Consider enactment on the state level of individual medical spending plans, as proposed in federal discussions about Medicare, and allow the retention of unused

funds over a lifetime for use in elder years.

- Develop sliding-fee scale co-payment systems for use statewide, and provide fund ing to support their use by safety net providers. Such systems would have to pro- vide for those persons who cannot afford any level of payment.
- Promote state and federal expansion of the ShowMe Healthy Women Program (for merly called the Breast and Cervical Cancer Control Program) to reach more women, making a broader age range eligible for its services, and expand its scope to include screenings for other diseases and conditions such as heart disease and colon cancer.

3. Make systems changes to improve access to comprehensive care for elderly and disabled women.
   - Improve public awareness of and access to the Missouri SenioRx program, possibly by administering it through Local Public Health Agencies.
   - Provide low-cost or no-cost in-home care services for the elderly and disabled.
   - Develop and/or enhance existing systems for transporting homebound patients to medical care, and ensure better transportation services in rural areas.
4. Ensure linguistically and culturally appropriate services throughout the state.
   - Promote training and use of multi-cultural, multi-lingual, and multi-racial providers.
   - Ensure that professional educational and training, including continuing education, prepares health care providers to care sensitively and appropriately for people who are from countries, cultures, and races different from theirs.
   - Create funding sources for implementation of Culturally and Linguistically Appropriate Services (CLAS) standards.
   - Develop programs that accelerate entry of foreign-trained health care professionals and that support them in meeting state licensure and other practice requirements.

Access to HIV/AIDS Prevention and Treatment Services[12]

Young people (13-29 years) account for about 35 percent of reported new HIV infections and 15 percent of the reported new AIDS cases in Missouri for the year 2002. Early in the history of this disease, African-American and black women did not view HIV infection as a threat, but today HIV is disproportionately infecting young women of color through heterosexual contact. For that reason, the following goal and strategies address young African-American and black women exclusively.

Goal: Primary and secondary HIV infection and AIDS prevention services will be available to young African-American and black women.

Socioeconomic, cultural, and gender barriers limit the ability of some young African-American and black women to protect themselves from sexually transmitted diseases (STDs), including HIV. Like other adolescents, many of these young women lack the knowledge and comfort necessary to talk about sexuality, sexual behaviors, and their own bodies. In addition, there are not enough well-funded prevention programs specifically focusing on young African-American and black women. Some of the factors affecting this at-risk population group include: poverty and lack of access to care; having sex with men who use injection drugs, are HIV-infected, or whose HIV status is unknown to the young woman; reluctance to ask about male partners' substance use or same-sex practices; discomfort about negotiating condom use with sexual partners; trusting male partners who are not monogamous; having multiple sexual partners; initiating sexual activity at early ages; and having sexual intercourse with older men (who are more likely than younger men to have had sex with multiple partners, varied sexual experiences, and/or a history of injection drug use).

strategies for access to HIV/AIDS services

1. Provide education about sexuality, including the prevention of HIV/AIDS, in schools throughout Missouri, beginning in late elementary school grades and continuing through high school, making use as appropriate of peer educational approaches and positive community role models.
2. Ensure that school educational programs focus on helping young people learn skills for making healthy decisions about their sexual behavior.
3. Assure that appropriate testing, pre/post-test counseling and reporting is available for young African-American and black women in alcohol and drug programs serving women and children.
4. Assure that young African-American and black women have access to female-controlled methods for preventing STDs, including HIV/AIDS, as well as the skills to use the methods correctly and consistently.
5. Encourage community-based comprehensive, integrated HIV/AIDS care that addresses the entire spectrum of health care needs.
6. Provide education and training for health care providers that stresses culturally appropriate and age appropriate communication and respect for both confidentiality and privacy.
7. Eliminate the barriers, including transportation, that prevent access to comprehensive health care for young African-American and black women.
8. Assure that health communication campaigns and risk reduction programs are targeted appropriately and sensitively to young African-American and black women, using appropriate media outlets, and involving the young women themselves in designing the informational and educational approaches and materials.

9. Adopt or adapt the Centers for Disease Control and Prevention program, "Prevention for Positives," and assure that prevention messages, risk assessment, and screening are incorporated into community-based primary care settings, especially those in which young African-American and black women receive their care.

Access to Reproductive Health Care

Goal: All Missouri women will have full access to reproductive health services and education, especially underserved women, including those women who are un- and under-insured, those who belong to racial and ethnic minorities, and those who live in poverty

The World Health Organization defines reproductive health as "a state of physical, mental, and social well-being in all matters related to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this are the rights of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health-care services that enable women to safely go through pregnancy and childbirth." The same organization defines reproductive health care as "the constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems."[13]

Key reproductive health indicators include rates of low birth weight, smoking during pregnancy, and infant mortality. Missouri has higher rates of these indicators than the country as a whole, and the data show significant racial and ethnic disparities. While seven percent of white infants in Missouri were born low birth weight in 2002, nearly 14 percent of African American infants were born low birth weight.[14] White women report smoking at a higher rate during pregnancy than African American women, according to 2002 data (19.4 percent versus 12.9 percent respectively), but these rates remain well above the Healthy People 2010 target of no more than one percent.[15] Infant mortality in Missouri actually rose from a 2001 rate of 7.4 per 1,000 births to a rate of 8.5 per 1,000 births in 2002. There is a significant disparity between rates for African American infants (17.2 per 1,000 births) and those for white infants (7.1 per 1,000 births). Rates for both groups are well above the Healthy People 2010 target of 4.5 per 1,000 births.[16]

Other important indicators of reproductive health are adequate prenatal care and maternal mortality. While over 91 percent of white women in Missouri received adequate prenatal care in 2002, only 79.5 percent of African American women did.[17] The risk of death from pregnancy has decreased nearly 99 percent during the twentieth century, yet rates remain well above the Healthy People 2010 target of 3.3 per 100,000 live births.[18] In 2000, ten maternal deaths were reported in Missouri vital statistics for a rate of 13.1 per 100,000 live births. With the definition of maternal death expanded to include deaths up to one year post pregnancy, Missouri's rate increases to 15.9— 11.2 deaths per 100,000 live white births and 35.6 deaths per 100,000 live births to African American women.[19] Maternal mortality remains an important reproduc-

tive health indicator requiring attention and intervention.

Pregnancies that are too widely spaced appear to raise the risk for the pregnancy complications pre-eclampsia and eclampsia, while pregnancies spaced too closely are very hard on the mother, causing nutritional depletion and physical and psychological stress. Too-closely spaced pregnancies also are hard on the baby: there is strong evidence that they increase the risks of intrauterine growth restriction, low birth weight, and preterm delivery.[20]

Teenage pregnancies, especially those of adolescents under 15 years of age, are associated with a constellation of factors that put the mother and baby at risk. Healthy People 2010 suggests that while no children under the age of 15 should get pregnant, a target of 43 pregnancies per 1,000 15-17 year olds is appropriate.[21] In Missouri, in 2002, pregnancies were reported at a rate of 27.8 per 1,000 15 - 17 year olds for all races and ethnicities, well below the national target, yet in 2002, the rate for white teens was 22 per 1,000 and the rate for African American and black teens, 60 per 1,000. Moreover, in 2001, there were 116 Missouri births to teens younger than 15 years.[22] Physically, young adolescents' uteruses and skeletons are not mature, and psychologically, teens this young are not ready for pregnancy, birth, and parenthood. In general, adolescent mothers do not have the resources they need to make decisions that are in their best interests when faced with pregnancies. There is evidence, too, that pregnant adolescents are at risk of abuse by older male partners and that a substantial number of adolescent pregnancies may be the result of sexual abuse. Further, these young women are at risk for not finishing high school, almost guaranteeing them and their babies a lifetime of dependence on their families and/or un- or under-employment and poverty. Babies born to such young girls have increased risk of being born too small; their rates of Sudden Infant Death Syndrome (SIDS) are higher; and, generally, they lack support for optimal development. These babies also have been shown to be at increased risk of being emotionally and physically abused.[23]

Smoking during pregnancy is associated with low birth weight babies and spontaneous abortion due to reduced oxygen that restricts intrauterine growth.[24] Prenatal smoking and smoking by the mother after the baby is born have been shown to be related to increased risk of SIDS and respiratory infections for the baby.[25] Yet 18.1 percent of pregnant women in Missouri smoked during pregnancy in 2002. In fact, as part of Missouri's comprehensive tobacco use prevention program, it is recommended that families not allow smoking in their homes.[26]

The prevalence of these risk factors and negative reproductive outcomes is higher among African-American and black women than among white and Hispanic women in Missouri, although white women have higher rates of smoking during pregnancy (19.4 percent) than African-American and black women (12.9 percent).[27] In this state, in 2002, African-American and black infants have higher premature birth rates (17.6 percent versus 9.7 percent for white infants), higher rates of low birth weight babies (13.9 percent versus 7 percent for white babies), and a very high rate of receiving inadequate prenatal care (21.5 percent versus 8.8 percent for white women).[28]

Of course, the greatest risk factor for poor health—not just reproductive health— is poverty,[29] and African-American and black women generally are more likely to be poor than white women. Even when their incomes and educational levels increase, however, African-American and black women are still at increased risk of having low-birth weight babies. There may be factors beyond poverty that contribute to these disparities in health status but that are yet not fully understood. Some researchers suggest that for women of color, generations of living in poverty cause loss of resilience and resistance, a phenomenon referred to as "weathering."[30]

As the definition given earlier suggests, reproductive health also includes freedom from sexually transmitted diseases (STDs) such as gonorrhea and chlamydia. These infections generally produce few or no symptoms for women, so unless women are screened for them, the infections remain undetected and untreated, spreading and contributing to pelvic inflammatory disease (PID), infertility, tubal pregnancies, and chronic pelvic pain.[31] Untreated chlamydia also is implicated as a risk factor for HIV infection. Among young Missouri women ages 10 to 14 years, the rate[32] of chlamydia is 112.42 and the rate of gonorrhea, nearly 54, while for women ages 15 to 24 years, those figures are 1809.74 and 709.15. Rates of these two common STDs decline as women age, but still are of concern. For example, among women 25-34, the rate for chlamydia is 277, and for gonorrhea, nearly 183. An even more common STD is the human papillomavirus, or HPV, which is estimated to be the STD with the highest incidence and which is implicated in cervical cancer[33]. In fact, Healthy People 2010 recommends a national strategy to reduce the proportion of persons with HPV infection.

For Missouri women, access to reproductive health services to prevent STDs and to assist in preparation for optimally healthy pregnancies was reduced in 2003. In that year, state funding that had supported family planning services in county health departments and community-based organizations was eliminated, leaving an estimated 33,000 poor or near-poor women without access to the broad range of preventive and primary care services that supports their reproductive health. The elimination of these funds means that women who have no private insurance, who are not eligible for Medicaid, and who cannot afford to pay no longer can receive the following care: pelvic examinations and Pap smears, clinical breast examinations for signs of cancer, STD testing and treatment, screening for heart disease risk, including height, weight and blood pressure checks, and counseling and supplies for contraception— all important components of well woman care. It should be noted that such services reduce the need for abortions, and for many of these women, the annual family planning visit was the only health care they received (outside of emergency room care for illness or injury). At the same time, eligibility for Pap tests through Missouri's Show Me Healthy Women Program (SMHWP, formerly the Breast and Cervical Cancer Control Program) that used to serve income-eligible women between the ages of 18 and 64 years was restricted to women ages 35-64 years. (Mammogram coverage in this program for income-eligible women ages 50-64 years remains unchanged from earlier coverage guidelines.) Early indications are that federal Title X family planning funds that come to Missouri through the Missouri Family Health Council cover only a small proportion of the 33,000 women in need of services.[34]

strategies for reproductive healthcare access

1. Restore and expand Missouri women's access to publicly funded women's health services.
2. Promote culturally-appropriate education about the importance of reproductive health care to women's health and well-being. Reproductive health education must include the following: a focus on preventing sexually transmitted diseases and information about optimal ages for childbearing, healthy birth spacing, and preparation for healthy pregnancies. Strategies to promote reproductive health education must be targeted to all levels of influence: Individual, Interpersonal, Organizational, Community/Schools/Employment, and Policy.
3. Promote the broadest possible definition of family planning in Missouri Medicaid rules. The scope of services should include the following: gynecological examinations, Pap tests, STD and HIV testing, FDA-approved forms of contraception and related counseling services, contraceptive sterilization, and preconception counseling.
4. Work with private insurance companies to provide insurance coverage for an expanded scope of reproductive health services.
5. Continue to support existing strategies and programs for ensuring early and adequate prenatal care for all women.
6. Incorporate scientific research findings about racial disparities in birth outcomes in development of new strategies and programs.
7. Develop policies and programs for the provision of training and support to private sector health care providers to promote screening for STDs, infertility, and genetic abnormalities.
8. Develop, implement, and evaluate an initiative to increase screening and treatment for Chlamydia and HPV.

Physical Activity and Healthy Nutrition

Goal: Missouri girls and women will engage in healthy amounts of physical activity and will practice healthy eating throughout their lifetimes in order to reduce their risk for chronic diseases such as heart disease, diabetes, osteoporosis, and certain cancers.

It is well known that engaging in physical activity and eating a healthy diet reduce several risk factors for developing chronic diseases such as heart disease, diabetes, high blood pressure, and arthritis and osteoporosis later in life.[35] Yet, Missouri girls and women generally weigh more and exercise less than their counterparts in many other states. For example, in surveys done in 2001,[36] 10.4 percent of young Missouri women in the 9th through 12th grades reported not having engaged in moderate or vigorous physical activity in the past seven days. Similarly, in 2003, 24.9 percent of Missouri women ages 18 years and older reported being physically inactive. In 2003, nearly 80 percent of women ages 18 years and older reported eating fewer than the recommended five daily servings of fruits and vegetables, and, in 2001, 84 percent of young women ages 13-19 years indicated that they do not eat the recommended amounts of these healthy foods.

Not surprising, given the facts above, over 26 percent of women ages 18 years and older reported in 2003 that they had been told by a health care provider that they were overweight (had a Body Mass Index of 25-29.9), while 19.3 percent reported being told they were obese (BMI of 30 or more). Nearly 9 percent of young women 13-19 years reported being told they were overweight.

strategies for healthy eating

1. Promote healthy foods in school vending machines and the a la carte section of school cafeterias.
2. Eliminate soft drinks and sweetened beverages on school campuses, as recommended by the American Academy of Pediatrics in a policy statement dated January 5, 2004, and provide healthy alternatives in vending machines and at school functions.
3. Increase access to fresh foods by supporting and expanding efforts to encourage use of Missouri agricultural products in schools, senior centers, and workplaces, as well as government programs that promote farmers' markets.
4. Encourage consumers of "fast food" to request nutrition information and to compare calorie values.
5. Promote implementation of the World Health Organization and UNICEF "Baby Friendly Hospital Initiative" in Missouri hospitals to promote breastfeeding from birth.
6. Increase the availability of time, facilities, and supplies for breastfeeding/lactation in the workplace.

7. Promote healthful food choices and use of local agricultural commodities such as fresh fruits and vegetables and whole grains in home-delivered and congregate meal programs.

8. Improve health education in schools through the following: (1) broader use throughout Missouri of the School Health Index; (2) including in school curriculum the concept of making healthful food and lifestyle choices; and (3) teaching students media literacy skills, including how to interpret media messages and advertising claims for food and dietary supplements.

strategies for healthy physical activity

1. Encourage pediatricians, education officials, and faith community leaders to promote reducing television viewing and use of other media to less than two hours a day, as recommended by the American Academy of Pediatrics.
2. Establish stable sources of funding for community programs that encourage exercise (i.e. walkable/safe communities and senior center activity programs) and that increase opportunities for youngsters, especially low-income youth, to engage in sports.
3. Encourage employers to build flex time for employees' physical activity into the workplace.
4. Mandate a specific number of hours of physical education and sufficient recess time to promote physical activity in schools, from kindergarten through twelfth grade, and offer extra credit for participation in school sports and activity programs.
5. Encourage development of after-school physical activity programs in addition to team sports.
6. Encourage churches, temples, and mosques to develop "Heart Healthy" congregations.

Freedom from Environmental Health Hazards

Goal: Missouri girls and women will have reduced exposure to environmental health hazards across the lifespan.

The World Health Organization defines environmental health as "those aspects of human health, disease, and injury that are determined or influenced by factors in the environment." Environment, including the natural and the man-made, or built, environments, is one of three primary factors affecting human health. Genetic factors and personal behaviors are the other two.[37] It is important to study environmental health factors

from a women's health point of view because "it cannot be assumed that the environment will affect women and men in the same way."[38]

In order to understand women's unique environmental health issues, far more research must be conducted with women as subjects. Women may well experience worse effects from environmental health exposures because of such factors as their higher percentage of body fat and their estrogen production and intake from oral contraceptives and hormone replacement therapy, yet not enough is known about the nature of the exposures or their effects on women's health over the life span. [39]

The hormonal and metabolic changes in women's lives can affect how environmental exposures will affect them. In defining environmental risks to women's health, it is important to focus broadly, to distinguish between risks to the health of the woman herself and risks to the development of a fetus, should she be pregnant.[40]

Here are some examples of ways in which women's environmental health issues differ from men's[41]:

- Women and men spend different amounts of time at home and often work in different kinds of settings, so they are exposed to different substances in different amounts.
- Women have higher percentages of body fat than men, and many environmental toxins are stored in body fat.
- Women who eat large amounts of sport-caught fish may be at greater risk than men for exposure to toxins such as PCBs, DDT (banned, but still present in the environment), and mercury, and many of these chemicals are stored in body fat.
- Women who spend much of their time in the home may be exposed there to solvents and pesticides in their daily home activities, as well as to substances such as radon.
- Some toxic metals such as mercury and lead are stored in bone, and women's hormonal and physiologic changes such as pregnancy, lactation, and menopause may affect the extent to which their bones retain such metals or release them into the bloodstream.
- Exposure to some environmental health hazards has been shown to be inversely related to income, and single women heading families often are poor. Women who live in older, poorly maintained housing are at particular risk of exposure to health hazards such as lead, mold, dust mites, environmental tobacco smoke, and the allergens from cockroaches, vermin, and pet dander.

Of concern to pregnant women, infants, and young children is exposure to lead—the leading pediatric environmental health hazard and one of the most preventable environmental health problems today. For decades, lead has been banned from automobile fuels, house paint, and other consumer products. Missouri, however, has towns with active lead mines, as well as the older housing stock that still has lead-based paint on and in it. These sources account for most of the ongoing exposure of pregnant women and children. The fetuses of pregnant women who are exposed to lead can be born prematurely or at low birth weight. These babies and

those exposed to lead in the environment after birth may experience serious developmental disabilities. Of the more than 65,900 Missouri children under six years of age who received blood lead tests in 2002, 4.6 percent had elevated blood levels,[42] putting their healthy development at significant risk. In adults, too, lead exposure may cause several adverse reactions, such as delayed reaction times, and, at higher levels of exposure, abdominal pain and infertility.

Asthma is the leading chronic illness in the United States in children, and in Missouri, it is the leading cause of hospitalization among children under the age of 15.[43] While asthma is not primarily a women's health issue (it occurs three times more frequently among males before puberty and is slightly more prevalent among African American children)[44] it still is of concern to girls and women. Eliminating exposure to second hand smoke is another key environmental health issue. The US government classifies second hand tobacco smoke as a Group A carcinogen, along with other substances considered the most dangerous to health (e.g., asbestos and radon).[45] Missouri recommends that managing childhood asthma should include controlling asthma allergens and cockroach allergens, cleaning up mold and controlling moisture, and reducing exposure to dust mites. Together with remediation of lead hazards and reduction of exposure to second hand tobacco smoke, such measures should be in place where women and children spend their time: at home, in the workplace, in child care facilities, and in senior housing facilities.

strategies for safe environments

1. Increase the number of workplaces (offices, factories, etc.) that ban smoking on the premises, or at least in the worksite.
2. Increase mothers' awareness of the health effects of smoking around their children, and develop programs to encourage parents who smoke to refrain from smoking in the household.
3. Increase the number of policies that prohibit smoking in public places and in work places, including in doorways or building entryways.
4. Enforce existing policies to lower levels of or eliminate environmental health hazards such as lead that are known to have substantial health risk.
5. Support efforts to require radon-resistant new construction in all new dwellings and to provide funding for low-income individuals to have radon mitigation systems installed in their homes.
6. Assess/evaluate/critique policies regulating the detection/prevention of environmental hazards in child care facilities, adult day care centers, and nursing homes.
7. Promote programs that educate homeowners about ways to make their homes healthier by controlling or eliminating substances that trigger asthma.
8. Promote programs that require owners of rental property to remediate hazards

such as deteriorating lead paint, cockroach and other vermin droppings, molds, and dust mites, and offer inducements for the remediation of rental properties.

9. Promote better tracking of environmental health hazards by sex, and promote research into the effects of environmental health hazards on the health of women, as distinct from fetuses and children.
10. Enhance programs that inform men and women of the need to limit the amount of sport-caught fish that they consume and of the special needs of women, especially pregnant women.

Avoidance of Tobacco Use

Goal: Girls and young women in Missouri will choose not to use tobacco.[46]

Goal: Girls and young and adult women in Missouri who use tobacco will quit.

Goal: Pregnant Missouri women will not smoke.

The American Lung Association reports that women smoke for different reasons than men do: women smoke to handle stress and maintain weight, while for men smoking is more often associated with pleasure and socializing. In the 1960s and 70s, when tobacco company advertising began to target women, the number of girls and young women ages 12-17 who smoked increased dramatically. From 1967 to 1973, as sales of women's cigarettes increased, smoking rates of 12 year old girls more than doubled. Missouri girls in grades 9-12 currently have a smoking rate of 30.4 percent, and 65 percent of those report that they are trying to quit smoking. Missouri's age-adjusted adult current smoking prevalence is 28.6 percent for men and 24.7 percent for women.[47] Over ten thousand people die in Missouri each year from tobacco-related diseases and conditions, and an additional 1,200 from exposure to environmental tobacco smoke.[48] Recent research suggests that women are twice as likely as men to develop lung cancer from smoking.[49] The lung cancer death rate for women in this state is 46.2 (per 100,000 women). Over 18 percent of Missouri women smoke during pregnancy, affecting their own health and that of their babies.[50]

Women also have a more difficult time than men in quitting smoking, and they are more likely than men to seek social support (such as support groups or counseling groups) for quitting.[51] Recent survey data in Missouri indicate that 61 percent of Missouri women report receiving smoking cessation advice from a physician.[52]

strategies for preventing tobacco use

1. Increase the excise tax on each pack of cigarettes to more than $1.00 and target the revenue from the tax to existing, evidence-based tobacco use prevention programs.
2. Increase pro-health knowledge, beliefs, and skills among girls and young women to recognize and resist social influences to use tobacco.

- Increase the number of schools that follow the CDC "Guidelines for School Health Programs to Prevent Tobacco Use and Addiction."
- Create tobacco-free environments in schools and communities, including prohibiting tobacco advertising on or near school grounds and prohibiting wearing clothing with tobacco company logos on school grounds.
- Decrease girls' access to tobacco products through enforcement of existing youth tobacco sales bans, and increase penalties on merchants who sell tobacco products to youth.

strategies for tobacco use cessation

1. Use media outlets to promote information about the addictive nature and health and social consequences of using tobacco.
2. Work with magazines and other print media headquartered in Missouri to decrease or eliminate tobacco advertising aimed at girls and women.
3. Develop and enforce bans in all Missouri schools against wearing clothing that promotes tobacco products.
4. Increase the number of girls and women who have health insurance.
5. Increase the availability of affordable and accessible cessation services such as telephone "quit lines," as well as full coverage of smoking cessation treatments in publicly-funded and private insurance plans.
6. Promote general public awareness of the national telephone "Quit Line."
7. Offer comprehensive smoking cessation programs under Medicaid.
8. Increase the number of primary health care providers and dentists who counsel their patients about tobacco cessation.

strategies for preventing tobacco use by pregnant women

1. Increase and enhance health care provider counseling of pregnant women about the harmful effects of smoking on the fetus, infants, and children.
2. Provide incentives for pregnant smokers to quit early and stay tobacco-free.
3. Provide tobacco cessation counseling through existing home visitation and prenatal care support programs.

Healthy Relationships

Violence against women takes several forms, including domestic violence, intimate partner violence, sexual assault and abuse, rape, incest, dating violence, and elder abuse. Violence can be categorized as: physical, sexual, threats of sexual or physical violence, and psychological/emotional abuse, including coercive tactics. Women are significantly more likely than men to be injured or killed during an assault. Violence against women crosses all age, racial and ethnic, religious, and socio-economic lines, and it is the leading cause of injury for American women between the ages of 15 and 54 years.[53]

Goal: All Missouri girls and women will be able to recognize, develop, and maintain healthy relationships; and all will have access to a network of support that enables them to leave unhealthy relationships.

Of Missouri women ages 18 and older surveyed in 1999, 30 percent reported experiencing an attempted or completed rape at least once in their life.[54] In 2000, there were 37,898 domestic violence cases reported to law enforcement agencies in Missouri.[55] This is higher than the national estimate of 18 percent from the 1999 National Violence Against Women Survey.[56] We know there are many more cases that are never reported. For example, in 2000, only 9,396 women in Missouri sought emergency room treatment or inpatient care as a result of being physically assaulted or raped.[57] Ten percent of female high school students in Missouri reported in 2001 that they were forced to have sexual intercourse when they did not want to; and 11.2 percent of twelfth graders reported forced sexual intercourse.[58] In 2001, 8.7 percent of female high school students in Missouri reported being hit, slapped, or physically hurt on purpose by their boyfriends during the past 12 months.[59]

strategies to prevent violence against women[60]

1. Determine which of the following competencies known to prevent violence effectively are being taught in Missouri schools (kindergarten through 12th grade): negotiation, critical thinking, and decision making; identifying, managing, and coping with feelings, including anger; anticipating the consequences of one's aggressive verbal and nonverbal behavior; finding nonviolent alternatives to conflict; and moral reasoning.
2. Develop, implement, and evaluate a plan for integrating violence-prevention competencies into all levels of Missouri's education system, from pre-school through college, with a special focus on high schools. Violence-prevention competencies include: negotiation, critical thinking, and decision making; identifying, managing, and coping with feelings, including anger; anticipating the consequences of one's aggressive verbal and nonverbal behavior; finding nonviolent alternatives to conflict; and moral reasoning.
3. Promote implementation of elements of "Violence Against Women: Missouri State Prevention Plan, Strategies for Action" throughout the state by funding planning and

implementation grants for community-based organizations and local health departments in urban, suburban, and rural communities.

strategies to remedy the effects of violence against women

1. Create community partnerships to address violence against women, ensuring that, at a minimum, the following are involved: law enforcement, prosecuting attorneys, advocates, service providers, domestic violence shelters, sexual assault response programs, businesses, and religious organizations, counseling services, schools, and other community organizations. Community participants should consider the cultural diversity of Missouri, differing needs in rural and urban areas, access to services, and socio-economic issues.
2. Mandate health care provider screening for violence against women (and provide support in terms of protocols and training).
3. Mandate consistent and reliable collection of data on the nature and prevalence of violence against women.

Safe Workplaces

Goal: Missouri women will be protected from assualts at work and from work-related injuries.

In general, national Bureau of Labor Statistics data[61] reveal that women suffer far fewer work injuries than men. Women make up just under half the workforce in this country, yet they incur less than a tenth of the total job-related fatalities and only a third of the total nonfatal injuries and illnesses that require time off for recuperation. The explanation is relatively simple: women generally are employed in less dangerous jobs (service occupations and teaching, for example) in more controlled, indoor environments than men. One of the leading causes of fatal injuries for women in the workplace were homicides, accounting for 40 percent of fatal injuries to women, and about 16 percent of these homicides were domestic disputes that spilled over into the workplace. Exposure to harmful substances or dangerous environments accounted for only four percent of women's workplace fatalities. Of the nonfatal injuries and illnesses, nearly half were the result of repetitive motion (carpal tunnel syndrome and tendonitis) and overexertion in lifting and pushing. Other of women's illnesses and injuries requiring time off for recuperation were classified as respiratory system diseases, infectious and parasitic diseases, and disorders resulting from anxiety and stress. Women also accounted for nearly two thirds of the non-fatal injuries resulting from workplace assaults, and most of those were from patients of women working in service industries such as nursing homes, hospitals, and other social service work settings. Missouri data, also from the Department of Labor, Bureau of Labor Statistics[62] reveal few surprises. In this state, as nationally, occupational injuries for men far exceed those for women, with the exception of repetitive motion injuries, especially key-entry and typing, classifications in which women experience far more injuries than men involving days away from work.

strategies for safe workplaces

1. Enact workplace policies to protect girls and women in their reproductive years against harm to future generations through secondary exposure to unhealthy substances in the work place and unhealthy physical working conditions.
2. Enact policies to protect women in the workplace from assault by partners/spouses, co-workers, or clients.
3. Enact policies for the primary and secondary prevention of repetitive motion injuries, and implement work place programs to educate workers about signs of such injuries.
4. Support national efforts to encourage manufacturers of workplace personal protective equipment to design such equipment to suit the body sizes and proportions of women.

Motor Vehicle Safety

Goal: Fewer Missouri teen and adult women will die or be injured in motor vehicle crashes.

National women's health data reveal that motor vehicle crashes (MVC) are a leading cause of death and injuries among girls and women. In Missouri, adolescent women (ages 15 to 24 years) have the highest rate of any age group for deaths from motor vehicle crashes— 20.9 percent. For adult women in this state, rates of death from motor vehicle crashes range from nearly 11 percent for women ages 25-34 years to over 17 percent for women between 65-74 years of age, with women ages 75-84 having a motor vehicle crash death rate of 20.5 percent.[63]

strategies for motor vehicle safety [64]

1. Develop and enforce laws and implement programs to reduce the incidence of driving under the influence of alcohol and drugs or being the passenger in a vehicle with such a driver.
2. Develop and implement programs to screen drivers for age-related driving impairments.
3. Strengthen and enforce state laws regarding use of safety belts and child safety seats.
4. Encourage development and implementation of local policies regarding use of safety belts and child safety seats.
5. Conduct community-wide enhanced enforcement and public awareness campaigns, targeted towards increased use of safety belts among teen girls and women, as well as appropriate use of child safety seats.

6. Develop and disseminate a "toolkit" that includes core elements of a comprehensive driver and passenger safety approach for communities, including resources and funding.
7. Provide information, technical assistance, and training to local communities to improve safety belt and child safety seat use.

Safe Homes

Goal: Fewer older adult women in Missouri will be injured in falls.

Falls are the leading cause of unintentional injury for all Missourians. Falls are an especially serious public health problem among older adults, and 64 percent of all injuries for older Missourians are the result of falls. Missourians over the age of 65 suffer fall-related injuries at a greater rate than any other age group: 5,075 per 100,000 population, with the rate of such injuries for women far greater than for men at 6,324 per 100,000. Most common fall-related injuries are osteoporotic fractures of the hip, spine, or forearm. Half of older adults who suffer a hip fracture never regain their previous level of functioning.[65]

strategies for safe homes

1. Expand the development of physical and social environmental changes at the community level such as sidewalks, walking trails, and community activity centers and walking/exercise clubs, ensuring that they are marketed to and accessible and affordable for women ages 40 years and older.
2. Include in community activity programs muscle-strengthening and balance-improving exercises especially geared to older women.
3. Promote health education for women of all ages about ways of preventing loss of muscle strength and bone mass, especially physical activity and strength-building exercises and appropriate use of vitamin, and mineral supplements.
4. Promote improved health care provider monitoring of older women's use of multiple pharmaceuticals and over-the-counter drugs and food, vitamin and mineral supplements in regular primary care visits and through annual assessments.
5. Standardize coverage for bone mass measurement tests in Medicaid and private insurance for women ages 40-65.
6. Standardize coverage for medication to prevent or treat bone loss for women ages 40 and older through private and public health coverage.
7. Expand existing mobile services for bone mass measurement tests and target them so that women ages 40 and older living in rural areas have increased access to them.

8. Promote regular screening for age-related vision impairments in health care settings, senior centers, and other places where older adults gather, and ensure availability of follow-up diagnosis and treatment for problems detected during such screenings.
9. Distribute existing fall-prevention guides for older adults through existing senior information and service networks.
10. Develop and support community volunteer programs to provide safety inspections using fall prevention guides, as well as retrofitting (e.g., with grab bars, stair rails, application of non-skid materials to stair treads, removal of worn carpeting and of throw rugs, lighting improvements) to increase safety from falls in the homes of older women.
11. Establish sources of funding for retrofitting older adults' private residences for safety.
12. Promote development of affordable and accessible housing that includes age or disability-related adaptations such as being built on just one level, ramps instead of stairs, special doorknobs, bath and shower arrangements, and appropriate lighting.

Next steps

By design, the strategies in this Framework are general, and there are no action steps included, nor are responsible parties and timelines specified. While the Department of Health and Senior Services can take the lead on many of these strategies, there are opportunities in this Framework for many partners. Indeed, to bring most of these strategies to life will take many state and local governmental agencies, legislators, and persons from professional organizations, academia, private businesses, corporations, and community based organizations. All of us, working together, can make a difference in the health of girls and women in Missouri. The next steps are all of ours. Where would you like to start?

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